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INSIDE



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# EDs Boost COVID-19 Vaccination Efforts

*By Dorothy Brooks*

At a time when COVID-19 cases are surging while doses of highly effective vaccines are available, a growing number of healthcare organizations are recognizing there is an opportunity for EDs to help vaccinate. The American College of Emergency Physicians has unveiled new resources for EDs interested in establishing vaccination programs.[1] Several pioneering programs have surmounted many logistical hurdles.

Some emergency providers may view COVID-19 vaccinations as another task piled on an already-full plate. However, EDs are uniquely positioned to reach many underserved and high-risk populations that have yet to receive protection from COVID-19.

**Elissa Schechter-Perkins**, MD, MPH, DTMH, director of emergency medicine infectious disease management at Boston University School of Medicine and Boston Medical Center (BMC), says she was thinking about providing COVID-19 vaccinations in the ED from the moment the first solutions were approved in late 2020.

"Many of us in emergency medicine really see the opportunity of using the ED to function as a public health environment because we are often the only contact that individuals have with the healthcare system," she explains. "We welcome the opportunity to improve our patients' health — not just from the perspective of the emergency that brought them in, but in a much bigger way. COVID-19 seemed right in line with that view."

Still, making the vaccines available in the ED at BMC required a multifaceted effort. "I approached our department leadership and our hospital leadership as well as our [Massachusetts] Department of Public Health," Schechter-Perkins explains. "Back at the time when vaccines were incredibly constrained ... I made the argument that there should be vaccines allocated specifically to EDs across the state in order to capture that [underserved] population."

In February, Massachusetts decided not to allocate doses to EDs, at least not while vaccine supplies remained constrained. But by mid-April, when shots were more plentiful, BMC decided to go forward with offering the COVID-19 vaccine in the ED. However, the timing proved problematic.



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Schechter-Perkins recalls going live with the ED vaccine program on April 13 at 7 a.m. — only for the FDA to announce about 90 minutes later the agency wanted to re-examine the Johnson & Johnson (J&J) vaccine BMC had picked.[2]

Ten days later, the FDA allowed providers to resume using the J&J vaccine.[3] It took some time for BMC to consider the FDA's findings and determine how to proceed. "We didn't finally go live again [with the vaccines] until May 13," Schechter-Perkins shares.

At BMC, administrators added a question about COVID-19 vaccination status to the screen all patients who present to the ED receive. This way, clinicians can see whether each individual has been vaccinated. If not, providers can offer the vaccine to any patient who will be discharged from the ED.

"We as an institution made the decision that admitted patients would not be eligible for consideration for getting the vaccination in the ED because we just didn't want to confuse the picture," Schechter-Perkins reports. "If someone developed side effects from the vaccine and spiked a fever in the hospital, it would be too challenging to know whether it was really a reaction to the vaccine or a complication from surgery."

While vaccine hesitancy is an issue, BMC leaders decided not to spend much effort collecting research about why patients were choosing not to receive the shot. "Our goal was to make the process as easy as possible and just offer the vaccine," Schechter-Perkins says.

However, she notes BMC created a variety of materials to address vaccine hesitancy in the community. These include guides to help clinicians hone their messaging when discussing the vaccine with patients who are uncertain.

Schechter-Perkins says about 100 patients (as of press time) have received the COVID-19 vaccine while in the BMC ED. While the number seems modest, Massachusetts has recorded one of the highest vaccination rates in the country. Many patients who present to the ED have received the shot. "This is 100 patients who probably wouldn't otherwise have been vaccinated at all because they had been eligible for the vaccine for a while and had chosen, for whatever reason, not to be vaccinated previously," Schechter-Perkins explains.

Nonetheless, the ED has bolstered its vaccination efforts. For example, in mid-July, BMC allocated two nurses to work in the ED from 8 a.m. to 5 p.m. every day. "They are there just to talk to patients about vaccines. We are taking this off of the shoulders of the physicians and putting it on the shoulders of these two dedicated nurses who don't have other ED responsibilities," Schechter-Perkins says.

Further, these nurses can offer all three available COVID-19 vaccines, not just the J&J solution. "We are still generally defaulting to the J&J vaccine because a lot of our patients are somewhat disconnected from the healthcare system. We are concerned that they might not make it back to a follow-up appointment [to receive a second dose]," Schechter-Perkins says. "However, if someone wants one of the other vaccines, we acknowledge that having one dose of the Moderna or Pfizer vaccine is certainly better than not having any doses."

If patients in the ED request the Pfizer or Moderna vaccines, the dedicated nurses will administer the first dose and make a follow-up appointment for patients to receive their

second dose in the hospital vaccine clinic, located within BMC, not far from the ED.

Schechter-Perkins says securing pharmacy support is "critical" because those in that department store the shots, mix the solutions, and maintain related documentation. Work with other key department heads to identify possible barriers and develop a plan to address them.

Also, ensure all ED providers and nurses are on board with the importance of making COVID-19 vaccinations a priority. "It is so easy to home in on the reason a patient is in the ED ... but taking a broader perspective allows you to think about the person's health in a different way," Schechter-Perkins says. "Part of that [involves] understanding how COVID-19 vaccination really ought to be a priority."

Rhode Island-based Lifespan Health System offers COVID-19 vaccines in all its EDs across the state. This was almost a natural evolution from what many ED personnel were already doing, according to **Anthony Napoli**, MD, medical director of emergency medicine and chair of the ED at Newport Hospital.

"We actually started to utilize ED staff on off hours or slow hours in the ED because of reports of anaphylaxis in response to the vaccine," he explains. "We set up the equivalent of high-risk clinics, and ED personnel were being asked to either work with [those clinics] or to be available for those patients because [the vaccinations] were new."

Lifespan leaders understood their EDs serve as a safety net for an often hard-to-reach population that public health authorities were targeting for the COVID-19 vaccine. "We tend to get patients that have more socioeconomic or demographic risk factors," Napoli says.

For instance, many patients are elderly, uninsured, or underinsured, and many speak a language other than English. The ED also sees plenty of patients with substance use disorders or other behavioral health concerns.

"Those are your real high-risk populations for not getting a COVID-19 vaccine, and they are exactly the populations of people who come to EDs disproportionately as compared to the general public," Napoli says. "We have populations that seek care in the ED that, frankly, don't seek care anywhere else."

To Napoli, it made sense to offer the COVID-19 vaccine through Lifespan's EDs. He took a leading role in establishing the program — first, by forming a team that included ED physicians, nursing leaders, and representatives from IT and pharmacy.

This group developed an order for the vaccine in the computer system, fine-tuned the process for thawing and mixing the medication into usable doses, and much more. "You have to time it such that you aren't wasting the vaccine. You [prepare the doses] at a time when you have the most patients who are eligible in the ED," Napoli observes.

While providers received education on how to address vaccine hesitancy, they were not given any suggested scripting. "The premise was if [a patient] develops a relationship with someone they trust during the ED encounter, then any discussion about that person's concerns regarding the vaccine would be something that occurs organically," Napoli shares. "They have the opportunity to ask questions that they might not otherwise ask, and therefore might not otherwise seek out a vaccine."

ED providers have overcome the hesitancy some patients have expressed regarding the vaccine. For instance, Napoli says if patients are concerned about potential complications, the provider can explain the risk of experiencing a medical complication is higher if they do not receive the vaccine.

"Being in the ED, you can speak with authority about the things you have seen and the concerns that you don't want to see in someone else, particularly the person in front of you. That helps a lot," Napoli says.

The ED-based vaccination program started in mid-April. The initial update was good, although demand for the vaccine has tapered. "In the early April period, we identified a need and we were planning as more vaccine was becoming available throughout the country," Napoli says. "Then, shortly after we rolled out the process, the amount of vaccine expanded significantly. Our state was quite successful at getting vaccines to populations at risk, particularly elderly populations and populations in targeted ZIP codes where there are people who are at risk."

Even with all the logistical steps involved, the ED-based vaccination program required no additional resources or staff beyond vaccine supplies. "This is the perfect sort of operation for a hospital-ED because it only involves small, incremental responsibilities for each individual," Napoli says. "The pharmacy has to make the vaccine, the emergency physician has to discuss it with the patient, and the nurse then has to administer it — but they administer medications all the time." ■

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# Healthcare Workers, Hospital Systems Clash Over Vaccine Mandates

*By Dorothy Brooks*

More healthcare systems are only taking "yes" for an answer when it comes to their employees receiving the COVID-19 vaccine. In turn, hundreds of employees are resigning or being dismissed because they refuse to take the shot. For instance, in late June, more than 150 employees of Houston Methodist Hospital lost their jobs because they did not comply with the hospital's vaccine mandate.[1]

While it may be hard to understand why a person at higher risk for contracting the virus might take issue with this requirement, the idea of mandating the vaccine as a condition of employment is simply too strong a push for some. However, a coalition of healthcare organizations is calling on all medical facilities to mandate the vaccines.

The group, which includes the Society for Healthcare Epidemiology of America (SHEA), the Infectious Diseases Society of America (IDSA), and five other medical groups, contends vaccine mandates are needed to end the pandemic.

In a statement issued by the coalition, **David J. Weber**, MD, MPH, FIDSA, FSHEA, a member of the SHEA Board of Trustees, noted the COVID-19 vaccines used in the United States have been shown to be safe and effective.

"By requiring vaccination as a condition of employment, we raise levels of vaccination for healthcare personnel, improve protection of our patients, and aid in reaching community protection," Weber said. "As healthcare personnel, we're committed to these goals."

The American College of Emergency Physicians (ACEP) is not a member of the coalition, and the group takes no position on mandates, but the organization strongly encourages its members to take the vaccine.

> "EMERGENCY PHYSICIANS ARE CRITICAL VOICES IN THE EFFORT TO ENCOURAGE EVERY ELIGIBLE PERSON TO GET THE VACCINE."

"Emergency physicians are critical voices in the effort to encourage every eligible person to get the vaccine," notes **Arvind Venkat**, MD, FACEP, an ACEP board member and the vice chair for research and faculty academic affairs in the department of emergency medicine at Allegheny Health Network in Pittsburgh. "Emergency physicians all over the country are taking steps to share information and increase the number of people who are vaccinated."

The Emergency Nurses Association (ENA), also not a member of the coalition, takes a similar tack to ACEP when asked about vaccine mandates.

"From our standpoint, we just highly encourage our members to follow the evidence, speak, and be a good role model for the patients they care for in the community they live in," says ENA President **Ron Kraus**, MSN, RN, EMT, CEN, ACNS-BC, TCRN. "For 19 years in a row now, nurses have been the most trusted profession. We have a social obligation to be that voice for the evidence, and to refute any false narrative out there — not only to our patients, but to our family members, our community, and our neighbors that we serve."

Kraus added emergency nurses are obligated to be "in the know" and to be able to answer any questions patients may ask so everyone can be vaccinated. ■

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# Watch Closely for Surge in Postural Orthostatic Tachycardia Syndrome Cases

*By Dorothy Brooks*

The list of long-term health problems affecting patients after recovering from COVID-19 continues growing. One of these lesser-known conditions is postural orthostatic tachycardia syndrome (POTS), a disorder of the autonomic nervous system. Reports of POTS have spiked in recent months.

Although treatments for POTS exist, the condition often is missed or misdiagnosed, leading to unnecessary suffering and anxiety for patients. However, given the condition's recent visibility, frontline providers could gain a new understanding of POTS while also providing patients with a fast, accurate explanation for their symptoms.

What makes POTS so challenging? **Pamela Taub**, MD, FACC, FASPC, associate clinical professor of medicine at the University of California, San Diego, says the condition is a heterogeneous syndrome in which patients can manifest many different symptoms.

"The hallmark of POTS is an elevation in the heart rate [of about 30 points] that occurs when someone goes from lying to standing," she explains. "But the problem is that patients don't walk into the office and tell you that their [heart] rate goes up by 30 points when they stand up. What they tell you is they don't feel great, they have brain fog, they have fatigue, they can't concentrate, they have blood pooling in their legs, or their stomach is upset."

Thus, Taub notes patients with the condition often go from provider to provider for months or even years, frequently leading to frustration and poor life quality, before finally receiving the correct diagnosis. It is a problem that could be corrected if frontline providers were more informed about POTS. "It has to be on your radar," Taub says. "If you are not thinking about it, then you are not going to do the correct testing to make the diagnosis."

When a provider suspects POTS, the primary test is simple. Ask the patient to lie flat for three to five minutes and take heart rate and blood pressure readings. Then, ask the patient to stand for another three to five minutes and check heart rate and blood pressure readings again.

If a clinician just takes blood pressure and heart rate readings while the patient is sitting, as is typical, he or she might not recognize the tachycardia that goes along with POTS. "You may see just a normal blood pressure and a normal heart rate," Taub says.

Consequently, if frontline clinicians suspect POTS could be behind a patient's symptoms, Taub suggests they take the extra step of recording orthostatic vitals. "That can really help to show you patterns," she says. "Even if there is not a 30-point increase in the heart rate, maybe there is a 20-point increase when the patient goes from lying to standing, which can tell clinicians that there is some physiology that is abnormal. Just getting the vitals and having that diagnosis on the radar is the first step."

POTS is more prevalent in women, especially younger patients, and it usually strikes those who are otherwise healthy. Further, POTS often follows a viral infection. This accounts for the surge in cases providers are seeing in patients who have recently experienced COVID-19.

"For many years, we have seen that pattern where someone gets something like the flu or mono. After that infection, they have symptoms of POTS," Taub shares. "COVID-19 is another viral infection. It is just more common and more prevalent worldwide [right now]."

Taub estimates she has seen about a 50% increase in patients with POTS. Many of these cases involve patients who have battled COVID-19. "The thing about post-COVID POTS is that people are not recognizing it immediately. There is often a little bit of a delay in people getting to myself and other colleagues," Taub observes. "Usually, [they present] about three months or so after they recover from COVID-19."

Typically, patients will recognize something is not right and will seek medical attention for their symptoms, but then it will take another three to six months before they make it to a provider with experience in treating POTS.

There are multiple medications that can help patients with POTS. For instance, Taub has published research on the efficacy of ivabradine.[1] However, she notes emergency providers may feel more comfortable referring patients to a specialist who can provide ongoing care to make specific treatment decisions.

Nonetheless, providing such patients with a diagnosis, letting them know that there are treatments available, and guiding them to a provider with experience in POTS treatment can go a long way toward providing relief. This is particularly true for patients who have been searching for

an explanation for their symptoms for many months, if not years.

Because POTS is such a complex disorder, many types of specialists are experienced in managing different facets of the illness. For example, cardiologists often manage patients with POTS, but neurologists might manage headaches patients experience, gastroenterologists can address gastroparesis or problems with digestion, and allergists can treat some immunologic manifestations. Further, rehabilitation experts can help with any physical limitations or impairments that arise. ■

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# Certain Recovery Activities Can Protect First Responders' Well-Being

*By Dorothy Brooks*

Considering the effects of stress on well-being, first responders are at higher risk of suffering from emotional fallout from their work. However, new research in this area suggests the extent is striking.

Investigators from Syracuse University concluded EMS workers face as much as three times the risk for significant mental health problems vs. the general population.[1] The good news is there are some straightforward solutions that could mitigate the harmful effects of stress and reduce their risk of developing depression, PTSD, or other mental health problems.

While these are early days in what investigators hope to be a longer-term project, they have uncovered a few concrete steps EMS workers and their colleagues can take to counter the harmful effects of their often highly charged work activities.

**Bryce Hruska**, PhD, assistant professor at Syracuse, says addressing the stressors and mental health challenges EMS workers face has been on his radar for a long time. "A lot of our research is focused on patient populations, but over the last several years I have been focused on occupational populations ... and EMTs in particular," he says. The most recognized risk factor facing EMTs relates to the kinds of critical events to which they respond. "These are events that may involve patient deaths [and/or] a threat of harm to other patients or even the EMTs themselves," Hruska observes. "What we know from the broader trauma literature is that these types of events are really distressing and difficult for all people to cope with. EMTs experience these events on a regular basis."

Hruska and a colleague recruited 79 EMS workers from a provider in central New York to complete a daily assessment of occupational stressors, along with measurements of PTSD and depression symptom severity. The assessment also included questions about sleep efficiency and social conflicts. In addition, respondents provided input on any social support they received, recovery activities in which they engaged, and any meaning or positive social impact they perceived coming from their work.

"We collected the data for eight days. We found that almost two-thirds of the people in the study experienced one [highly stressful, critical event] just over the course of eight days," Hruska reports. "If you extrapolate that out to the whole year, it ends up being 29 events per year, and that is for each person." On top of experiencing frequent critical events, EMTs typically work demanding schedules, often enduring day-long shifts on little sleep. Hruska believes this produces "a cumulative effect," which was evident in the study.

For instance, the researchers reported each additional work demand or critical event an EMS worker experienced on a given work day was associated with a 5% increase in their PTSD symptom severity levels that day. Each social conflict was associated with a 12% increase in their depression symptom severity level.

While the research was conducted in 2019, the COVID-19 pandemic only heightened the worry and stress for EMTs. "We had a lot of existing public health problems, and COVID made a lot of them worse," Hruska shares, noting in particular the rise in overdose deaths and general violence.

Understanding the challenges EMS workers face was an important aspect of the study, Hruska also studied what kinds of behaviors or activities EMS workers already are engaging in to navigate these challenges.

"People who found some meaning in the day's challenges ... that is one thing that we found was protective and helped people's mental health," Hruska says. For example, if an EMT was in conflict with a colleague, the worker would think about how he

could improve his communication tactics for the next day, rather than just stewing about a negative situation. In other cases, workers would find some helpful lesson or pointer from their work that day that could help them improve.

Investigators also identified what they refer to as recovery activities, specific behaviors that proved protective of well-being. These included social activities such as sharing a meal with other people at the end of a shift.

"After people experience stressful events, the social support that occurs in the aftermath can be very helpful," Hruska notes.

EMS workers can use this fellowship to conceptualize stress and potentially draw meaning from the stressful event. Similarly, exercising or playing a sport was associated with a reduction in depression and stress-related symptoms each day. "We know that when people respond to stressful events, they've got a lot of physiological activation," Hruska notes. "Exercise or sports activities can allow you to expend that physiological drive and get back to a kind of baseline level of functioning."

While individual EMS workers can take it upon themselves to engage in recovery activities, EMS leaders can help, too. Hruska suggests that in the aftermath of a critical event, set aside dedicated down time. "This provides time for workers to recover and to make sense of the event," Hruska says. "It is also helpful to do some form of internal debrief after a bit of time has passed."

Hruska also suggests putting policies in place that promote healthy behaviors. "Exercise is a big one, and we know it is important for a variety of reasons," he says. "Some EMS agencies have dedicated space so that workers can exercise in between shifts or before or after a shift." Such spaces can serve the dual purpose of promoting exercise while also providing an area where workers can socialize.

EMS leaders also should consider the finding that social conflicts can cause a spike in depression symptoms among EMS workers.

"These involved conflicts that would occur during the day with co-workers, supervisors, or ... people who are not at work," Hruska shares. "One potential actionable item for employers is to find some ways to promote or refine communication strategies that are used between workers." Hruska suggests thinking about ways to facilitate proactive, healthy communication when EMS staff members are working through various stressful situations.

Building on the findings of this research, investigators hope to turn their attention to creating tools that EMS workers and leaders can use to nurture overall worker well-being. "The plan is to try a brief intervention where we have workers think about the challenges they experience during the day, and kind of guide them toward finding some meaning that they can extract from them," Hruska explains.

Further, Hruska wants to pair this intervention with methods to promote the beneficial recovery activities that were highlighted in the first phase of the research. "We know that when people do more of these recovery activities they also have different psychological experiences that may be helpful," he notes. ■

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# Test Ordering Mistakes Are Issue in Most Diagnosis-Related ED Malpractice Claims

*By Stacey Kusterbeck*

Diagnostic-related ED malpractice lawsuits frequently allege test ordering mistakes, according to a recent analysis.[1] Making the correct diagnosis in the ED "is like trying to put together a puzzle without having the picture on the cover of the box," says **Dana Siegal**, RN, CPHRM, CPPS, director of patient safety for CRICO Strategies, a division of the Risk Management Foundation of the Harvard Medical Institutions.

The top allegation in most ED cases (56%) is diagnosis-related, according to the analysis of 3,212 closed claims in CRICO Strategies' Comparative Benchmarking System (CBS), a database of medical malpractice claims. Of diagnosis-related ED claims, 65% involved a test ordering issue. "ED cases that end up as malpractice claims are most often cases where there's something acute going on that gets missed," Siegal observes, adding that ED malpractice claims involving a test ordering issue "often come back to information and communication."

Discharge "timeouts" are a chance for the entire ED team to ask two

important questions: Is all the information in? If not, can the patient still be discharged? "Maybe some tests aren't back. But the providers really feel that, based on the concurrent monitoring, that it is safe to discharge somebody," Siegal offers.

It does not make sense to hold an ED patient for many hours waiting on test results if there is enough evidence to conclude it is safe to discharge the patient. To reduce risks in this situation, EDs can inform patients that some tests have not returned, and check vital signs right before the patient leaves.

"One of the huge voids we found in ED medical records where we missed the diagnosis was there were no discharge vital signs," Siegal reports.

Most ED charts included at least one set of initial vital signs. Some charts contained another set of vital signs that were recorded sometime during the ED visit, but few contained vital signs recorded immediately before discharge. "Discharge vital signs are a last check to see if things are changing or evolving. Quite often, they are missing," Siegel laments.

During the discharge timeout, ED providers can verify vital signs are documented and evaluate any that are abnormal (e.g., ascertaining if elevated pulse rate is just caused by fluids that were administered, or if something else is going on). Discharge timeouts can catch patients who should not be discharged, and could confirm why it is safe to discharge a patient even with incomplete test results. However, missed diagnoses caused by anchoring or confirmation bias still happen.

"Analysis of ED claims repeatedly demonstrated that biases like these can impact cases much earlier in the diagnostic process. We realized that there is an opportunity to interrupt the error process by meeting sooner than discharge," Siegal says.

Diagnostic timeouts happen earlier in the process, giving the ED team a chance to share everything they know. "Before we even start going down the final diagnostic path, let's be sure we have all the puzzle pieces," Siegal says. "Information is not always in the EHR."

New information can completely change the picture for patients who initially did not seem too concerning. "Everybody thinks that the big failures in the ED are the code blues — somebody went into cardiac arrest, and we didn't rescue them. That is really not where our vulnerabilities are," Siegal explains.

Many claims in the CRICO analysis involved patients who were overlooked because they did not present with an obvious acute issue. "They don't present themselves as loudly. Those are the patients that often get lost in the shuffle," Siegal notes.

Team training — on communication skills, monitoring patients, and sharing information while the patient still is in the ED — can ensure the correct tests are ordered and acted on. "While we have the patient with us, we need to be trying to learn as much as we possibly can," Siegal stresses. "So much of this is still dependent on human conversation and thinking out loud together."

In claims where testing issues were connected to misdiagnosis, these were common allegations:

**• ED providers did not order the correct tests.** "The challenge is we don't always order the right tests to get the right information," Siegal laments.

In some cases, the ED team goes down the wrong diagnostic path because a patient convincingly explains away his or her own symptoms. For example, an obese man with chest pain mentions eating pizza for lunch and lifting something heavy, not wanting to confront the possibility of a heart attack.

In other cases, the ECG looks normal, and the patient is discharged home (with instructions for follow-up care) because there is a reasonable explanation for the symptoms. "But if we didn't order cardiac enzymes, we might be missing that the patient has an evolving heart attack," Siegal explains.

Sometimes, ED providers are tripped up by the many biases known to affect the diagnostic process — confirmation bias, for example, where the emergency physician (EP) starts the workup with a diagnosis in mind and works to confirm it. "Here is where a negative test result might rule out one diagnosis and incorrectly support the 'confirmation' of another direction," Siegal says.

For example, a negative D-dimer in a patient with chest pain, shortness of breath, and rapid pulse leads the EP to "rule out" a pulmonary embolism (PE) and head down the cardiac pathway. In fact, a chest CT would have identified the PE, even in the face of a negative D-dimer.

Reassessments may reveal that different tests are needed. "What's going on with the patient right in front of them is important information," Siegal says.

A child admitted with mild fever records a higher temperature; a woman with non-specific chest pain and "anxiety" is reporting jaw pain. "Quite often, we are building our picture on the initial presentation. But now it's four hours later, and something is clearly evolving before our very eyes," Siegal says.

The EP orders a regular X-ray for a patient with non-traumatic neck

pain, but might consider an MRI if the patient begins complaining of leg numbness. But the MRI is ordered only if the new information is shared with the EP. "EDs are busy, demands on staff are high, and missed communication is a key factor in many cases," Siegal notes.

The ED nurse probably believes the leg numbness has been communicated if it is documented in the record. However, the EP might not review the nursing notes, expecting to be verbally informed of significant changes. "Both of them are right. But we are busy and running around, and we don't talk," Siegal says.

Comments from the patient's spouse, child, anyone accompanying the patient, the patient's primary care provider, or a consultant all contribute to the evolving diagnostic picture. The triage nurse may see a picture suggestive of gastroesophageal reflux disease and indigestion. Walking back to the treatment area, though, the patient mentions his father died of a ruptured abdominal aortic aneurysm. "That is a critical piece of information. But the person walking the patient to the room was the nursing assistant, and assumes the triage nurse already has that as part of the patient's history," Siegal says.

The patient does not mention it again, and the information is lost. "One obstacle that is often cited is the EHR," Siegal reports.

While helpful in consolidating information in one place, the EHR also can be an obstacle when information is not added, or navigation makes it difficult to see the big picture. To find the correct diagnosis, "multiple providers need to be gathering information. It's dependent on them putting it all in the same place," Siegal says.

Plaintiff attorneys often argue the standard of care required the EP to order a specific test or radiology study. "We see this in cases where the alleged symptoms fit multiple potential diagnoses," says **Edna McLain**, JD, a partner in the Chicago office of Smith Amundsen.

Common symptoms, such as chest pain or back pain, could be indicative of numerous medical conditions. For the plaintiff attorney, the two relevant questions are going to be: Was the medical condition on the differential diagnosis? Should a test have been ordered to rule that condition in or out? "Good documentation demonstrates the EP's thought process," McLain says.

Many EPs do not document what is on the differential diagnosis or if a condition is ruled out. When testifying months or years later, it is going to be difficult for EPs to remember what was considered at the time of the visit. "At times, the plaintiff attorney will say the diagnosis was not on the differential — or, that the ED physician considered it very low on the differential diagnosis and did not properly rule it in or out," McLain explains.

**• ED providers ordered the correct tests, but did not wait for the test result to return — and nobody followed up with the patient.** Some ED malpractice claims in the CRICO analysis involved cardiac enzymes that initially returned normal. In those lawsuits, the focus became why the EP ordered the test in the first place if the patient was just going to be discharged without even waiting for the results. Typically, the ED is crowded, and the patient, who appears stable, is eager to be discharged home. Then, the next set of enzymes returns abnormal. "The patient is already gone, and post-discharge follow-up falls through," Siegal says.

**• The initial reading of the test is negative, but the overread reveals something abnormal.** "In ED cases involving radiology reads, the initial result is often read by a resident, or perhaps by telemedicine in the middle of the night," Siegal says.

The initial findings are reassuring; there is no bleeding in the brain, no pneumonia, and no fracture. The EP discharges the patient home. The next day, the final read reveals something abnormal. This is a second chance to make the correct diagnosis, but communication breakdowns can stand in the way. "It's reported to the ED. But now you have a totally different team involved who doesn't remember, or even know, the patient," Siegal says.

Of the 1,797 ED diagnosis-related cases in the study, 7% involved post-discharge follow-up (including pending test results). "If there is not a specific process in place to document and follow up on these revised findings, the result never reaches the patient," Siegal says. ■

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## COMING IN FUTURE MONTHS

- New insight on managing *Clostridioides difficile*
- A proactive approach to handling alcohol abuse cases
- Liability for hospitals if ransomware harms ED patient
- ED lawsuits allege delayed neurology or cardiology consults

# ED Nurses Feel Unprepared for Mental Health Complaints

*By Stacey Kusterbeck*

ED nurses reported a general concern regarding treating patients with mental illness, according to the results of a recent qualitative study.[1] "The motivation for the study came from my past experience as an ED social worker," says **Amanda Ryan**, LMSW, the study's lead author and a doctoral student/graduate research assistant at the University of Texas at Arlington School of Social Work.

Ryan and colleagues reviewed five studies and identified three themes: ED nurses feeling unprepared and unqualified to care for behavioral health patients, feeling anxious and hesitant, and feeling concerned about keeping the patient environment safe. As an ED social worker, Ryan heard many nurses share similar feelings. "My experiences with psychiatric patients are different than the nurses who care for them, and I believe it is vital for frontline nursing staff to share their own varying experiences," Ryan says.

For ED triage nurses, behavioral health patients "can pose very high-risk situations," says **Seth Thomas**, MD, FACEP, director of quality and performance for Vituity's emergency medicine service line. ED nurses "need to get much more comfortable caring for these patients," Thomas adds. There are some specific legal risks Thomas sees for ED nurses:

**• Triage nurses could miss a life-threatening psychiatric emergency.** "If the triage process isn't running efficiently, it could delay evaluation of patients," Thomas cautions.

Patients will not always directly say they are presenting for psychiatric reasons. Instead, they might report vague complaints, and ED nurses send these patients to the waiting room. "More people are suffering from mental health disease than ED nurses would expect," Thomas offers.

Thomas suggests ED triage nurses expand their index of suspicion for a psychiatric emergency and document observations of the patient's behavior and demeanor in addition to the chief complaint.

**• Nurses might fail to monitor ED patients adequately, who then elope from the ED and harm themselves or others.** "That patient could walk out and harm themselves or somebody else," Thomas laments.

**• Triage nurses might fail to follow policies.** If so, "the hospital can be dragged into a lawsuit as a defendant," Thomas cautions.

Typically, the EP and hospital are the main targets of malpractice litigation. "But if the plaintiff attorney discovers that an ED nurse stepped outside of their scope of practice, such as medicating or restraining a patient without a physician's order, or failed to follow their hospital's policies or procedures, that could be a significant risk for the nurse," Thomas explains.

Good documentation helps nurses refute allegations in malpractice lawsuits involving psychiatric patients who spent a long time in the ED. "The boarding issue is only getting worse. The sheer number of patients and their length of stay is increasing tremendously," Thomas notes.

That means psychiatric patients are staying in EDs for many hours, days, or even weeks.[2] "Injuries often occur when patients escalate — not only to the patient, but the staff as well. Something will eventually happen if they stay in the ED long enough," Thomas warns.

Engaging with the patient can help ED nurses avoid these risky situations. Nurses can notice subtle signs of escalation, treat with medications when appropriate, offer food, perform regular assessments, and facilitate hygiene. "The ED chart should always demonstrate that ED nurses were doing their best to care for the patient," Thomas suggests.

It also is important for ED nurses to demonstrate they did everything in their power to transfer the patient to a higher level of care, if that is what the patient needs. "If a receiving hospital refuses acceptance, ED nurses should document the reason, and then try another hospital and document those encounters, too," Thomas says.

Lack of capacity at inpatient facilities is a real problem for EDs. "But I think we tend to blame the system a little too much, rather than saying, 'What can we do to help while they are here?'" Thomas observes.

It is reasonable for ED nurses to note "an inpatient bed was not available" or "a consultant was not available" or "the ED lacked a complete medication list." However, the overarching message in the ED nursing notes should be, "But we tried nonetheless. Here's what we did."

Too often, nursing notes are sparse on what happened during a psychiatric patient's stay. Sometimes, the chart states only the patient was medicated and restrained, which complicates malpractice defense. "You want to document the great care that you are

giving patients, by illustrating that in the medical record," Thomas says.

Frequent reassessments can demonstrate thorough care and reveal the patient actually received better care during the ED visit. "We strive to place patients in the least restrictive environment, which might be an outpatient crisis center. Or, it might even be home rather than in a hospital," Thomas says.

For psychiatric discharges, nurses should consider whether the patient has decision-making capacity and fully understands the discharge plan, the patient has no intent to harm herself or others, and the patient received outpatient resources (if appropriate). "Like all other patients, nurses should document that the patient is a 'safe discharge,'" Thomas adds.

**Kimberly Nordstrom**, MD, JD, says these are the top risk management concerns for ED nurses caring for psychiatric patients:

• **Appropriate monitoring of the suicidal patient.** "Hospitals have been aggressive in changing front-door policies," says Nordstrom, an emergency psychiatrist at University of Colorado Anschutz.

Some EDs have implemented more screenings for suicidal thoughts. "But after the triage screening, not all hospitals have solid procedures in place to ensure safety for the suicidal patient," Nordstrom laments.

EDs might lack 1:1 monitoring (or the ability to monitor patients in a room with a camera), fail to secure personal items (to prevent overdose on home medications or strangulation), or fail to have someone who evaluates the patient's actual risk in a timely manner.

• **Medication errors.** "This is always a concern for nursing, but especially when working rapidly to help tranquilize an agitated patient," Nordstrom says.

In these intense, high-stress interactions, mistakes can happen, such as giving too much medication or not reviewing the patient's allergy list. During litigation, nurses can expect to be asked several questions: Did the nurse receive a verbal or written order for the medications? If verbal, was there a clear order with exact milligrams of each medication stated? Did the nurse repeat the order back to the physician to ensure accurate understanding?

• **Treatment of the agitated patient.** "Nurses do not tend to have a lot of training in de-escalation techniques," Nordstrom notes.

Nurses are in the tough position of containing patients until security and/or behavioral health personnel are available. In some EDs, nurses play a role in physically restraining patients. "The priority is twofold: keeping both the patient as well as the staff safe. Nurses can get physically injured while keeping others safe," Nordstrom observes.

ED nurses should understand applicable mental health laws. "Some laws are very strict around use of restraints and what needs to be documented to support use," Nordstrom cautions.

Requirements may differ depending on the setting, such as an ED or inpatient mental health unit. In Colorado, requirements are more stringent for facilities that are specifically designated for mental health treatment, according to Nordstrom. "Most of the EDs have opted out of this designation and, because of this, have less stringent rules," she says.

EDs might be required to document that less restrictive measures were tried and found not to be successful, or that the patient was informed of the reason for restraints and/or what needs to occur to be taken out of restraints. "When a person screens positive for suicide risk, having ED policies that clearly outline next steps in care — further evaluation or safety protocols — is essential," Nordstrom adds. ■

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# Data Reveal Pediatric EPs' Biases, Both Implicit and Explicit

*By Stacey Kusterbeck*

Pediatric EPs carry implicit biases, unconscious negative attitudes toward specific groups (Black, Hispanic, and obese patients), according to the authors of a recent study.[1] "Our goal is to understand what biases — implicit and explicit — may exist in medical staff in the ED," says **Eric Fleegler**, MD, MPH, FAAP, one of the study's authors and assistant professor of pediatrics and emergency medicine at Harvard Medical School.

Fleegler and colleagues assessed both implicit and explicit biases of 101 pediatric EPs based on race, weight, and ethnicity. The explicit measures showed a weak preference for Black over white patients, no preferences between Hispanic and white patients, and a moderate preference for thin over obese patients. The implicit measures demonstrated a strong implicit bias against Hispanic, Black, and obese patients. The EPs surveyed did not report explicit bias against Black or Hispanic patients, but did show explicit bias against obese patients.

The researchers would like to use these data to determine if biases affect actual care. For example, in a busy ED, when a patient presents in pain, quick decisions are made about which medications are used to treat the pain, including acetaminophen, ibuprofen, and opioids. "Implicit biases against certain groups may lead to decreased utilization of opioids or other medications that may do a better job of relieving pain," Fleegler says.

Fleegler and colleagues recommended EDs consider self-screening for implicit bias so EPs can improve their own awareness (e.g., The Implicit Association Test; learn more here: https://bit.ly/37hXHBw). "I have spent nearly 30 years working to improve the care of everyone, with a particular focus on marginalized and unserved groups. To see my own implicit biases was humbling," Fleegler reports.

The survey's findings suggest ED providers probably do not treat everyone equally. This is true of pain management, antibiotic use, imaging, and child abuse evaluations. Another recent study revealed a lower rate of opioid use in Black and Hispanic children vs. white children with long bone fractures and suspected appendicitis.[2] "We need to be aware of this," says Fleegler, who worked on that study, too. "We need to understand the role of implicit biases in these decisions and work toward equitable care for all regardless of their race, ethnicity, or weight."

Elsewhere, other investigators have found Black patients are more likely to be physically restrained in EDs vs. white patients.[3,4] Black patients also are less likely to be given narcotic analgesics vs. white patients.[5] "Implicit assumptions, based on the stereotypes that Black individuals are aggressive and have higher pain tolerance, may contribute to the disparities seen in use of physical restraints and pain treatments," says **Erin Dehon**, PhD, associate professor in the department of emergency medicine and vice chair of diversity, equity, and inclusion at the University of Mississippi Medical Center in Jackson.

Individuals are more likely to unintentionally rely on stereotypes when they are multitasking, working under time pressure, working with a limited amount of information, or experiencing fatigue, according to Dehon. "Given these factors, ED physicians in particular may be at high risk," she suggests.

There are many factors, including unconscious bias, that may influence EPs' clinical interactions and decision-making. "While we think that our decisions are based purely on science, that is not always the case," says **Bernard L. Lopez**, MD, MS, CPE, senior associate dean for diversity and community engagement and professor and executive vice chair in the department of emergency medicine at Thomas Jefferson University Sidney Kimmel Medical College. One example of whether unconscious bias may play a role is women with chest pain. Studies have demonstrated disparities in outcomes in acute coronary syndrome based on gender. "While treatment decisions are complex, unconscious bias may have a significant role in these differences," Lopez says. "Unconscious bias at play may result in less accurate diagnoses and less aggressive treatment — and may result in poorer outcomes."

ED providers probably do not hold any overt bias toward women with acute coronary symptoms. "However, unconscious biases — the biases that are at play outside of our awareness — can cause a difference in treatment and outcomes based on gender. That's how unconscious bias works," Lopez says.

Education (e.g., lectures, seminars, and workshops) can mitigate unconscious bias. "While a one-time lecture can be informative, more in-depth education, especially ones that include an experiential component, can better educate one for the long term," Lopez

offers. Shorter, more frequent sessions are recommended to keep bias top of mind. "It takes a growth mindset — awareness, coupled with a desire to learn and improve — to best tackle unconscious bias," Lopez explains.

ED providers can point out cases to each other where bias might be playing a role. "If you have a blind spot, having somebody who does not share that same blind spot can help you recognize it," Lopez says.

EDs also can incorporate identifying disparities into their quality improvement process, according to Dehon. EDs could start by asking, "What disparities are unique to the ED setting?"

"Start by extracting potential health disparity data, such as restraint use, pain medication, lab test ordering, [and] assigned acuity levels at triage, from the EHR, stratified by race/ethnicity, gender, socioeconomic status, and any other relevant variables, to create a health disparities dashboard," Dehon says.

Based on those findings, the next step is for EDs to develop interventions to alleviate subjectivity (and, therefore, reduce the potential for bias to affect decision-making). Standardized protocols or specific algorithms are examples of this.

For instance, the data may reveal white patients are far more likely to be assigned higher acuity levels at triage compared to Black patients. If so, Dehon says EDs should ask these questions: Why is this occurring? How is triage level assigned? Is it purely subjective? How can the process be altered so that it's more objective? Is there an algorithm that could be applied? "Use the dashboard to monitor improvements over time," Dehon adds. ■

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# Potential Plaintiffs in ED Malpractice Claims Face Long Odds

*By Stacey Kusterbeck*

The vast majority of the time, ED patients who call an attorney hoping to sue for malpractice are turned down. The reasons are many. "Based on conversations with experienced medical malpractice attorneys over the last 35 years, I would estimate that fewer than 10% of the cases presented are accepted by lawyers specializing in professional liability claims," says **Richard F. Cahill**, JD, vice president and associate general counsel of Napa, CA-based The Doctors Company.

During the initial phone call or meeting, complainants often provide a compelling narrative, but it falls apart after an independent expert reviews the ED chart. False or misleading statements about what happened in the ED "undermine the patient's credibility. It destroys the trust necessary to support an ongoing attorney-client representation," Cahill says.

The cost of filing a malpractice lawsuit, and the low odds of prevailing, mean long odds for patients looking to become plaintiffs. "Most individuals seeking redress for adverse medical or hospital events are unable to retain an attorney willing to represent them," Cahill says.

If damages are low, few attorneys will be interested. Cahill offers this example of a case with marginal liability and minimal damages: A patient presents to an ED with moderate upper respiratory symptoms, waiting nearly three hours before being seen. During the prolonged wait, the patient suffered discomfort and anxiety. Due diligence by the prospective attorney reveals the other side of the story: The ED was inundated with numerous severely injured victims of a multivehicle car accident. Despite the delay, the diagnosis and treatment for the potential client were entirely

appropriate. "Undoubtedly, a high percentage of attorneys would decline to represent the patient in that situation," Cahill says. Pursuing medical negligence claims "presents numerous procedural and substantive challenges for all parties involved; is invariably expensive, both economically and emotionally; and results in an unfavorable outcome for the patient-plaintiff in more than 70% of cases," Cahill adds.

One thing that makes ED malpractice cases so costly is the standard of care at issue must be established by expert testimony. In emergency medicine cases, the patient may have been treated by clinicians across multiple specialties. This means more costly experts are needed to prove the case, according to **Elizabeth A. Harris**, JD, associate attorney in the health care and life sciences practice in the Washington, DC, office of Epstein Becker Green.

Plaintiff attorneys conduct due diligence in determining if an ED patient will be accepted as a client in several ways:

- Interview the patient, family members, friends, or others who know the circumstances of the situation. "The goal at this stage is to gather preliminary information, appraise the credibility of witnesses, and estimate the likely range of economic recovery," Cahill explains.
- Obtain the relevant medical records.
- Secure a supportive independent opinion by a physician expert or forensic nurse reviewer.

Attorneys look for red flags in the ED chart. It is a bad sign if the patient was combative, verbally abusive, noncompliant, or uncooperative during the visit. It also is problematic if the patient left the ED against medical advice. "An unsympathetic patient creates an increased challenge for counsel to persuade a judge, jury, or arbitrator that the case merits a finding of liability and an award of monetary damages," Cahill says.

Intake calls to a law firm come in all the time from patients, family members, or referring attorneys. Few turn into lawsuits. "Most plaintiff attorneys take 20% or less of those persons who call," estimates **Susan Martin**, Esq., executive vice president of litigation management and loss control at Fort Lauderdale, FL-based Best Practices Insurance Services.

In addition to the expert's opinion, attorneys consider other factors. "Attorneys look at whether it's a likable client with a credible story, and will also look at the venue to see if that county is more or less favorable to plaintiff attorneys," Martin reports.

As the case is evaluated, the attorney keeps in mind that to prevail, the plaintiff must prove there was a standard of care violation, the violation led to the injury (also known as causation), and there were damages. All this requires an expert opinion to establish. "Many times, there is a violation of the standard of care, but causation is difficult," Martin notes.

A ruptured thoracic aneurysm in the ED is a good example. One prospective case involved an obese man with a long history of uncontrolled hypertension who presented to a rural hospital without a 24-hour operating room. The patient coded after an evaluation by the EP, who was waiting for the results of radiological studies. The patient could not be resuscitated, and was pronounced dead in the ED. The family wanted to sue, but causation was a problem. "As most experts will opine, unless you are very close to an operating room, these type of aneurysms are not survivable," Martin says.

A plaintiff expert might prove the patient could have been transferred sooner, and the defense expert may concede this point. The problem for the plaintiff is a quicker transfer would have made no difference to the bad outcome; in other words, the patient would have died anyway. "Most reputable plaintiff attorneys would not consider this a medical malpractice case, as causation would be difficult to impossible to prove," Martin says. "There is no lawsuit."

With so many promising cases rejected, plaintiff attorneys spend a lot of time explaining why a lawsuit is not going to happen. Sometimes, the family is angry. Others actually are relieved there was no wrongdoing. "The family may feel remorse or guilt over something that occurred. Maybe they didn't go to the ED quickly enough or didn't believe it was really life-threatening," Martin suggests.

For an ED case to make financial sense, there must be damages. "Many times, the damages can be the real problem," Martin says.

This happens with some missed appendicitis cases. In one such episode, a young woman presented to an ED for right lower quadrant pain and was discharged with diagnosis of ovarian cyst. The patient saw an OB/GYN the next day, as instructed by the EP, and was immediately sent to the hospital to see a surgeon. She underwent an appendectomy and recovered.

It is true this patient really should have undergone a further workup in the ED. Finding an expert to state there was a violation of the standard of care would not be too difficult. However, even if the ED had made the correct diagnosis, the patient would have undergone the appendectomy a day earlier, with the same outcome. "She had the same amount of time in the hospital, with a same or similar procedure, which would have occurred anyway. There are no real damages," Martin says. ■

# 95% of Calls on ED Malpractice Lawsuits Are Rejected

*By Stacey Kusterbeck*

The first question **Michael M. Wilson**, MD, JD, asks potential clients is: "What serious, permanent injury did you suffer?"

"This question eliminates about 95% of all calls about ED malpractice," says Wilson, a Washington, DC-based healthcare attorney.

Many callers start off by complaining about how they were stuck in an ED waiting room for many hours. That does not equate to malpractice. The claims evaluation process for ED claims is somewhat more complex than other settings, since many patients see specialists after the ED visit. "It is simply not possible to provide ultimate definitive care in an ED setting to every patient presenting with a new and frequently unique constellation of medical issues," Wilson explains.

For example, if a patient reports falling on an outstretched hand, the ED may take plain film X-rays and miss a hand fracture. Later, a hand specialist diagnoses the fracture with the aid of hand film X-rays in additional positions. "The ED treatment is by an ED generalist in a limited period of time, determined to triage the patient and to direct that patient to appropriate further care with subspecialists," Wilson says.

Complainants are angry the ED provider misdiagnosed them and they want to sue for malpractice. "The patients frequently bring complex medical and surgical problems and do not appreciate the difference between ED care and subspecialty care," Wilson observes.

From the first contact, lawyers and staff are weighing which cases to reject outright and which are worth investigating further. To make the first cut, the claim must be associated with serious, permanent injuries (e.g., hemiplegia, paraplegia, total blindness, amputation of limbs, or permanent brain damage). Of that group, only some cases merit further investigation. Cases in which causation is impossible to prove are rejected. "Assuming that the decision is made to investigate the case, the first expense is to obtain the medical record and X-rays, if taken," Wilson says.

Usually, patients can learn some information from the patient portal. The lawyer reviews those records, sometimes with the help of an in-house expert. "These actions involve a time expense, which can be significant," Wilson says.

An outside expert reviews every case the firm decides to take. "These would be cases in an attractive venue, with catastrophic damages and probable malpractice," Wilson says. An example would be a relatively young patient who was kept waiting in the ED with an occlusive stroke until it was too late to pursue tPA treatment, leaving the patient hemiplegic.

About 5% of initial inquiries undergo an expert review. Experts usually charge about $500 per hour, with most records reviewed within two hours, at least for a preliminary review. Of that 5%, the firm conducts further investigation on 75%. "About half of those cases then proceed on to settlement or trial," Wilson reports. "Each law firm's numbers will vary, of course."

Some strong cases end up rejected after the expert review because of insufficient damages. "Our current threshold is that we do not take on a new case unless the expected settlement exceeds $500,000," Wilson says.

Attorneys provide other options if a case is rejected. Complainants are encouraged to go to other firms, to file a complaint with the state bar association or state medical board, seek advice from law school legal aid clinics, or go to small claims court. Wilson emphasizes his is just one firm; each practice decides which cases to pursue. It is common for one firm to take a case that others turned down. Sometimes, their case has probable merit, but there is a conflict of interest because the likely defendant is one of the law firm's experts in another medical malpractice case.

"Just because we turn a case down does not mean that they do not have a viable medical malpractice case," Wilson emphasizes. ■

## CME/CE OBJECTIVES

After completing this activity, participants will be able to:

1. Apply new information about various approaches to ED management;
2. Identify and explain the legal and regulatory issues related to the delivery of emergency services;
3. Implement effective operational procedures and risk management into daily practice.

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# CME/CE QUESTIONS

1. **Which is true regarding ED nurses and behavioral health patients?**

   a. ED triage nurses can reduce risks by increasing their index of suspicion for a psychiatric emergency.
   b. ED nurses are held liable for providing one-to-one monitoring for patients who do not meet criteria.
   c. Longer length of stay is linked to better outcomes.
   d. Decision-making capacity should not be a factor in determining whether it is safe to discharge.

2. **Which did a recent study reveal regarding pediatric EPs' bias?**

   a. Explicit bias against Black patients
   b. Explicit bias against obese patients
   c. Implicit bias against white patients
   d. Explicit bias against Hispanic patients

3. **Which is true regarding malpractice cases?**

   a. Most individuals seeking redress for adverse medical or hospital events cannot retain an attorney willing to represent them.
   b. Most ED malpractice cases result in a favorable outcome for the plaintiff.
   c. The fact the patient left the ED against medical advice has no bearing on whether an attorney agrees to pursue a malpractice case.
   d. If the plaintiff attorney can prove ED providers blatantly violated the standard of care, causation is irrelevant.

4. **What group will be instrumental in efforts to create an ED-based vaccination program?**

   a. Community health workers
   b. Adjunct nurses
   c. Hospital pharmacies
   d. Public health officials

5. **If a clinician just takes blood pressure and heart rate readings while a patient is sitting, as is typical, what hallmark sign of postural orthostatic tachycardia syndrome might be missed?**

   a. Fatigue
   b. Upset stomach
   c. Dizziness
   d. Rapid heart rate

6. **Which is true, according to an analysis of closed ED malpractice claims?**

   a. Discharge timeouts are linked to allegations of premature discharge.
   b. Discharging patients with abnormal vital signs constitutes a breach of the care standard.
   c. Informing patients about the process for reviewing tests makes lawsuits more likely.
   d. Some ED charts did not document discharge vital signs.

7. **An analysis revealed most diagnosis-related ED malpractice claims involve:**

   a. patients who went into cardiac arrest.
   b. patients who could not be resuscitated.
   c. a test ordering issue.
   d. patients with an obvious acute issue.